Guardianship Referral Form

Client Name:________________________________ Date of Referral:________________________

Referring Agency:____

Contact Person:______________________________ Relationship:___________________________

Phone Number:_______________________________ Email:_________________________________

General Information

Home Address:____

Status of Home: Own ___ Rent ____ Living Alone? Yes____ No ____

Marital Status: Married ____ Divorced ____ Separated ____ Never Married ____ Widowed ____

Nursing Facility:_____________________________ Date of Admission:______________________

Date of Birth:_______________________________ Place of Birth:_________________________

Social Security #:____________________________ Medicare #:____________________________

Medicaid ID #:______________________________ Medicaid Case #:_______________________

Describe the client's ability to communicate:____

____

Medical Information

Physician's Name and Phone #:____

Psychiatrist's Name and Phone #:____

Dentist's Name and Phone #:____

Optometrist's Name and Phone #:____

Current Diagnosis (Please attach current History and Physical report):____________________

____

____

Advance Directives: Full Code ____ No Code ____ Living Will ____

Any immediate health care concerns? Explain:____

____

Personal Contacts

Please list any and all family members:

Name Relationship Address Phone # Level of Involvement

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____

Please list any involved friends:

Name Address Phone # Level of Involvement

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Spouse Information

Spouse's Name:______________________________ Social Security #:_______________________

Current status: ____ Divorced (Date): ____________ ____ Deceased (Date):__________________

Spouse's Date of Birth:________________________

Military Service: Yes ____ No ____ Branch:__________________ Discharge Date:_________________

Former Spouse(s):____

Legal Information

Does this person currently have any form of advocate? (Power of Attorney, Healthcare Representative, Representative Payee, Guardian?) Yes____ No____

(Please list or include copies of any documentation pertaining to this.)_____________________

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Does the client have a will? Yes____ No____ Name of will holder:______________________________

Any pending legal action? Yes____ No____ Please describe:__________________________________

Life Insurance

Life Insurance: Yes ____ No ____ Company Name:____

Phone #:________________________ Policy Number:___________________________________

Type of Insurance: Whole Life ____ Term Life ____ Paid in full? Yes ____ No ____

Name of Beneficiary:______________________ Address:____________________________________

Phone #:_________________________________

Health Insurance

Medicare: Yes ____ No ____ Type: Part A ____ Part B ____ Part D ____

Medicare Part D Provider: ______________________ Policy #: ______________________

Medicare Replacement Insurance: Yes ____ No ____

Provider: ______________________ Policy #: ______________________

Medicaid: Yes ____ No ____ Caseworker's Name: ______________ Phone #: ______________

Other Health Insurance: Yes ____ No ____ Company Name: ______________________

Policy #: ______________________ Phone #: ______________________

Address: ____

Financial Information

Monthly Income: (ex: SSA, SSI, SSDI, Pension, etc.)

Amount: ______________ Source: ______________________

Amount: ______________ Source: ______________________

Amount: ______________ Source: ______________________

Bank Account: Yes ____ No ____ Name of Bank: ______________________

Address: ______________________ Phone #: ______________________

Checking Account: Yes ____ No ____ Account #: ______________________

Savings Account: Yes ____ No ____ Account #: ______________________

Resident Account: Yes ____ No ____ Account #: ______________________

Other (list): ______________ Relevant Info: ______________________

Other (list): ______________ Relevant Info: ______________________

Current Debts and Creditors:

Rent: $__________ Mortgage: $__________ Utilities: $__________

Loans: $______________ Other: $______________________

Credit Cards: $__________ Credit Card Company(s): ______________________

Real Estate

Please complete this section only if the client owns real estate

Address of Property:____

Property Type: House ____ Mobile Home ____ Other ____

Previous Address:____

Mortgage Type: Traditional ____ Reverse ____ Balloon ____

Mortgage Paid in Full? Yes ____ No ____ Total Owed $________ Monthly Payment: $____________

Mortgage Company Name:____

Address:______________________________ Phone #:______________________________

Years Owned:____________ Are there any liens against the property? Yes ____ No ____

Lien Holder:______________________________ Amount Owed $______________________

Are taxes current? Yes ____ No ____ Back Taxes Owed: $______________________

Funeral/Burial Arrangements

Funeral Home:__________________________ Address:______________________________

Phone #:______________________________ Fax #:______________________________

Pre-Paid Plan or Trust: Yes ____ No ____ Paid in full ____ Amount Owed: $____________________

Company Name:__________________________ Policy #:______________________________

Burial ____ Cremation ____ Cemetery Name:____________________ Phone #:______________

Own Plot? Yes ____ No ____ Paid in full ____ Amount Owed: $______________

Location of Plot:__________________________

Own Vault? Yes ____ No ____ Paid in Full? Yes ____ No ____ Amount Owed: $______________

Own Headstone? Yes ____ No ____ Paid in Full? Yes ____ No ____ Amount Owed: $______________

Own Marker? Yes ____ No ____ Paid in Full? Yes ____ No ____ Amount Owed: $______________

Other

Religious Preference:____

Church Preference:____

Education: 8th Grade or Less ____ 12th Grade or Less ____

High School Graduate ____ Post High School Degree ____

Other Pertinent Information

Why is guardianship being pursued?____

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Please provide any additional information that may be useful in determining whether this client is eligible for Guardianship services through Thrive Alliance:____

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Please return this referral along with a completed Physician's Statement confirming the incapacity of the referred person to:

Thrive Alliance, Attn: Guardianship Services
1531 13th Street Suite G900
Columbus, IN 47201
Phone: 812-314-2785 Fax: 812-372-7846